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ABSTRACT

Intended for regular education teachers of mainstreamed handicapped students, the booklet offers nontechnical information about dealing with children who have a variety of disabilities. A brief introduction traces the evolution of society's attitudes and school practices involving handicapped students. The second unit contains definitions, information on developmental and learning characteristics, and suggested teaching strategies for the following disabilities: mental retardation, learning disabilities, emotional disturbances, visual impairments, hearing impairments, orthopedic handicaps, developmental disabilities, and child abuse and neglect. A section on student assessment and evaluation covers formal and informal measures, readiness testing, tests of intellectual functioning, and diagnosis of learning disabilities. The final section presents a glossary of approximately 60 terms and a brief bibliography. (CL)

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TEACHING HANDICAPPED CHILDREN

A RESOURCE GUIDE

FOR

CLASSROOM TEACHERS

ED232371

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Bob Lister, Vic Hnatiuk
Special Education Department
Portsmouth Senior High School
Portsmouth, New Hampshire

EC 152651

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

To The Reader:

This booklet has been developed as an alternative information source for classroom teachers dealing with handicapped students within the mainstream of education.

The need for a publication of this type was expressed by classroom teachers, administrators and specialists in several school districts throughout the state. Our response to this initial statement of need was to explore the feasibility of producing and disseminating a document of this nature for classroom teachers. Computer searches and consultations with professionals from George Peabody College of Vanderbilt University, Rutgers College, and the State University System of New Hampshire were the catalysts for our initial research.

From the information gathered, we began developing a brief, nontechnical publication to aid teachers in their understanding, education and instruction of handicapped students in their classrooms.

This booklet is designed primarily for classroom teachers who have little or no formal training background in the area of Special Education. Upon completion of this booklet, it is not expected that one become an expert in the field of education of the handicapped. We do, however, hope that the reader will become more sensitive toward the social, vocational and academic needs of the handicapped student and will seek further information from resources available within their own school district and community.

It has been extremely difficult to choose which teaching strategies would be most appropriate for each individual area of disability. During the development of this publication, we decided to list a sample of teaching strategies for each area of deficiency, hoping that the reader would investigate further strategies using some of the materials listed in the bibliography.

Our expectations for you, the reader, are that you will gain some general information about handicapped students and that you will be better equipped to deal with the exceptional child in your classroom.

Bob Lister

Vic Hnatiuk

We would like to express our gratitude to the Portsmouth School Board (Curriculum Committee) for the initial funding of this project.

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UNIT 1 Introduction

INTRODUCTION

Tremendous changes have taken place in society's attitudes toward the handicapped. Historically, there are three stages of the development of attitudes concerning the handicapped (Kirk 1972). During the Christian Era, the handicapped were persecuted, neglected and mistreated. Second, during the period of Christianity, they were protected and pitied. In recent years, there has been a movement toward the acceptance of the handicapped and the integration of handicapped citizens into society. The trend to place handicapped students into public schools began in the early 1900's.

Much of the progress made in the education of the handicapped came about with the introduction of two separate pieces of federal legislation. The first of these was Section 504 of the Rehabilitation Act of 1973. In this law, certain practices in dealing with the handicapped were mandated. Included in these provisions were non-discriminatory practices towards handicapped students in educational programs and physical accessibility to all programs in the public education setting. The second of these laws, P.L. 94-142, mandated that free and appropriate programs be available to all educationally handicapped students. It should be noted that the major thrust behind this legislation was provided through lobbying of handicapped citizens themselves.

Special Education today encompasses a wide range of services aimed at helping handicapped students, aiding other educators in dealing with the handicapped and developing community awareness to aid in the integration of handicapped individuals into all aspects of the working society.

The first of these three roles of Special Education deals with direct educational services for handicapped students. These services vary according to the nature and severity of the students handicap. Services offered for a mildly retarded student would differ greatly from those services available to a hearing impaired student. A mildly retarded student may be involved with a Resource Room Program for a part of the school day while a hearing impaired child, placed in regular classes, may only require the services of an interpreter. The trend for providing programs for mildly handicapped students has been to provide services in cost effective programs within the local school districts. In more severe cases, such as the severely mentally retarded child, placements in residential settings are more common.

Due to the recent movement of mainstreaming special needs students into regular classes, special educators need to provide other professionals with appropriate strategies for dealing with handicapped individuals in their classrooms. These services take the form of in-service workshops, consultative sessions and development of appropriate resource materials.

In order to provide an on-going delivery of services, Special Educators are becoming increasingly involved with the development of community awareness toward the handicapped person. To assure a successful transition from the school world to the world of work, much communication and cooperation must take place between school personnel and community leaders.

With the continued support of remedial educational services and a community-wide commitment, handicapped individuals will be able to lead productive and meaningful lives in today's society.

UNIT 2 Handicapping Conditions

MENTAL RETARDATION

MENTAL RETARDATION

Preface

In general terms, there are three accepted sub-groupings for the classification of mentally retarded students. These classifications are; (a) educable mentally retarded (EMR), (b) trainable mentally retarded (TMR) and (c) custodial mentally retarded. These three sub-groups constitute a population of seven million people in the United States or an estimated 3% of the nation's total population. Of these people, several million will require some form of special services within a public school setting at some time during their lives.

Due to our concern with the public education of the retarded, we will provide the reader with information regarding the educable retarded (EMR) and trainable mentally retarded (TMR). Our discussion of the custodial sub-grouping will be minimal as this population usually receives services in institutions or residential settings.

A. DEFINITION

"Mental Retardation refers to significantly sub-average general intellectual functioning, along with deficits in adaptive behavior which is manifested during the developmental period." (Kirk, 1972, p. 163)

Generally, classification of the mentally retarded is based upon data from some form of intelligence testing: Intelligence Quotient (IQ). While it is true that no person should be classified solely on the basis of his or her IQ, the following IQ's are suggested as guidelines for the classification of individuals within the three sub-groups:

Educable Mentally Retarded (EMR) 79-50

Trainable Mentally Retarded (TMR) 49-25

Custodial Mentally Retarded 25 and below

B. DEVELOPMENTAL CHARACTERISTICS

The Educable Mentally Retarded

An educable mentally retarded student is one who, because of subnormal mental development, is unable to profit sufficiently from the regular educational programs offered in the public schools.

In most instances the educable student's growth lag in mental and social activities can be noted only if observed closely during the preschool years. Most of the time, the growth is normal and problems are not evident until the individual shows poor learning ability in school. In most instances, there are no obvious pathological conditions that account for his retardation. In 1972 Kirk outlined curriculum in the following manner:

1) Elementary - Can develop social and communication skills; minimal retardation in sensory motor areas; difficulties arise in academic situations, learning to read, etc.

2) Junior High School - Continued lag in academic and social growth, low academic levels can usually attain up to the 6th grade academic level.

3) Senior High School - Can usually achieve social and vocational skills to adequate level of self-support, may require guidance during social or emotional stress.

TRAINABLE MENTALLY RETARDED

The trainable mentally retarded student is one who is not educable in the sense of academic achievement, independent social adjustment, or independent occupational adjustment at the adult level. It is these factors that differentiate a trainable student from an educable student.

In most instances, trainable children will be identified as retarded during infancy or early childhood. This form of retardation is generally noted at an earlier time due to known clinical stigma or physical deviations in the child. Also these children are markedly delayed in talking and walking.

1) Elementary - Can talk and learn to communicate, poor social awareness, fair motor development, self-help training skills are necessary.

2) Junior High School - Can profit from training in social and pre-vocational skills, not likely to go beyond second grade level or academics.

3) Senior High School - Can be aided in semi-skilled work situations under sheltered conditions. Requires supervision during social or emotional periods of stress. (Kirk, 1972)

CUSTODIAL MENTALLY RETARDED

The totally dependent child is one who, because of severe mental retardation is unable to be trained in total self-care, socialization or economic usefulness.

Such individuals require almost complete care and supervision throughout their lives, most often in some type of institutional setting.

C. LEARNING CHARACTERISTICS

Educable Mentally Retarded

a) The EMR student usually performs poorly on verbal and non-verbal intelligence tests, scoring between 50 and 80. This indicates a development rate of one-half to three-quarters that of the average child. The EMR student may also be slower in conceptual and perceptual tasks.

b) The EMR student is usually not ready for school subjects (reading, writing, math, etc.) at the usual age of 6, but rather several years later. Progressing at a slower rate than others, the individual will probably attain a level of second to sixth grade in functional academic skills.

c) The EMR students' interests and social traits usually correspond more closely to other students of equal mental age (IQ), rather than students who are chronologically (age) his peers.

Trainable Mentally Retarded

a) The TMR student scores between 25 and 50 on a standard intelligence test. He is expected to develop at a rate of one-half to one-third that of a normal child.

b) The TMR student is not usually capable of achieving in ordinary academic subjects, but can learn self-care tasks, common safety rules and daily living skills.

c) The TMR child can learn social adjustment skills in everyday situations and is capable of some individual skills in the home or in a sheltered, supervised environment, such as a sheltered workshop.

D. TEACHING STRATEGIES

EMR

I. Elementary Level

The specific objectives for the EMR student at this level should include 1) the development of competencies that promote personal, social and vocational adjustments; 2) appropriate habits that promote health, physical development and safety and 3) readiness for basic school subjects. In 1971 Waite (p.105) provided guidance for developing teaching strategies in these areas.

A. Personal/Social Adjustment

Students should be encouraged to develop self-confidence and effectiveness in interacting with others. Students should experience success in social activities and be guided to expand their activities and interests. Limits should be placed on students to reduce anxiety, but enough freedom should be allowed for exploration and expansion of the child's world through supervised activities. Communication with others and self-expression should be learned throughout the process.

B. Appropriate Habits

The foundations laid at this level serve as a base for developing general competencies for social, academic, and vocational experiences. Some attitudes and habits that are vital include: following instructions, listening skills, completing routine tasks, taking orders and following rules.

Appropriate health habits revolve around self-help skills. Activities that establish habits of neatness, personal hygiene, and understanding basic body functions are all considered appropriate at this level.

In the area of physical development, activities should promote muscle development and coordination. Development of good habits toward physical fitness are also suggested. An adaptive physical education program is sometimes necessary for the more individualized needs of these handicapped students.

Finally, the development of safety habits should be addressed in the elementary curriculum. A "safety vocabulary" should be developed to allow the student to recognize danger signs in the environment (RR, Stop, Walk).

C. Readiness for School Subjects

Developing readiness for school subjects should also be a major part of the elementary program. Activities should promote readiness for the development of: 1) oral language arts; 2) written language arts; 3) number concepts and; 4) other basic school subjects. These readiness skills should include listening skills (oral language arts), visual discrimination, word recognition (written language arts), quantitative concepts (mathematics) and a basic science, or nature vocabulary.

II. Junior High School

The specific objectives for the junior high school level should include: 1) the development of competencies that promote personal, social and vocational admustment; 2) activities that lead to emotional security and independence; 3) further proficiency at basic school subjects; 4) habits promoting personal health, physical development and safety; 5) understanding the family structure and individual roles of family members; and 6) leisure time and recreational activities.

A. Personal/Social/Vocational Adjustment

EMR students should learn to recognize their abilities in handling social situations. If common problems are discussed before they arise, the student is then better equipped to cope with the situation when it occurs (smoking, drugs, drinking, dating, etc.). It is important to aid the EMR junior high school student in developing acceptable attitudes and behaviors toward the opposite sex. The program must contain provisions to aid these students in learning accepted roles and developing consistent behavior in relation to these roles. Students should learn to take on responsibility in social and personal areas through activities such as field trips, dances, extra-curricular group activities, and membership in community organizations (scouts, church organizations, etc.).

B. Emotional Security

Security and independence may be developed by a carefully designed instructional and guidance program. It is imperative that students experience success in the learning situation. They must also face the reality of criticism and failure, but in a manner that allows them to develop coping mechanisms for these experiences. The teacher should provide personal guidance and support throughout an instructional program geared toward the improvement of personal competencies.

C. Basic School Subjects

The junior high school program should also include remedial instruction in the basic academic areas. These areas include oral language arts, written language arts, mathematics and general science.

In the area of oral language arts, activities should encourage development of listening skills related to following directions, vocabulary expansion and continuation of the elementary objectives.

The written language development program should be continued with an emphasis on hand writing (letters, stories, essays), enrichment of reading skills, (reading signs, instructions, labels, etc.) and development of grammar and spelling.

The area of mathematics should include activities involving the four basic operations of mathematics with an emphasis on life situations requiring these mathematical skills (balancing a checking account, budgets, handling money, telling time, etc.).

The science curriculum should deal with subjects such as the earth and other planets, the seasons, time and weather. Again, functional application of this information should be stressed, (storm identification, identification of poisons, etc.).

D. Promoting Health, Physical Development and Safety

Adapting the health habits mastered on the elementary level to meet the changing needs of the adolescent is not a simple task. Opportunities to strengthen and re-form habits must be a part of the program. The individual must also learn such things as the practical roles of the medical profession (doctor, dentist, nurse, etc.), simple symptoms indicating a need for medical attention, basic first aid, and personal safety.

Physical development activities should encourage both group, team and individual play. Activities should stress the involvement and enjoyment of the sport.

Safety education should include such topics as recognizing dangerous situations, rules of the road for bike riders, and accident prevention in the home, school and community.

E. Family Unit and Member Roles

Instruction in this area should stress topics such as responsibilities of the husband, wife and children in the family unit. Respect for others in the home situation, obedience towards parents, and respect for other individuals are also important topic areas.

F. Recreational and Leisure Time Skills

Junior high students should be exposed to the importance of developing skills needed in recreational and leisure time activities. Two major areas of importance for these students would be: 1) where to locate recreational activities in their community and 2) understanding the basic rules of the various activities or sports they are interested in.

SECONDARY PROGRAM

The objectives of the secondary program are geared to prepare the student to make the transition from the school to the working world. The objectives are geared around the preparation of the individual for the world of work. These objectives are to develop: 1) skills and attitudes for personal and social competence; 2) skills and attitudes for vocational competence; 3) emotional security and independent functioning; 4) personal health, physical fitness and safety habits; 5) family living and family management skills; 6) community awareness and contribution of the student; 7) recreational/leisure time skills; and 8) successful work experience placements.

A. Personal and Social Competence

This portion of the secondary program should devote much time to the student's development of responsibility. This is a primary step in the student entering the working world and should not be omitted or overlooked. Other activities including conversational skills, following directions (written and oral), accepting constructive criticism, appropriate dress for school and work, and development of hobbies and casual interests will also be a part of this area.

B. Vocational Skills

The major goal of a secondary special education program for handicapped students is to prepare students to get jobs and keep them. They should be helped to develop such skills as locating a job, applying for a job, basic work habits before being placed in a work experience position. Also, specific trade vocabulary, abilities, skills and attitudes must be developed if the student is placed in a specific Vocational Education Program (welding, vocational foods, building trades, etc.).

C. Emotional Security

All activities in this area should aim to develop an appropriate self-image for the student. Students should be helped to succeed and also to deal with any frustration in an acceptable manner. Students must be prepared to deal with the demands that society will place upon them once they leave the school environment (punctuality, consistency, etc.).

D. Health, Physical Development and Safety

Activities to develop adequate habits in these areas are essential. Personal health habits, grooming, dietary needs, physical fitness, dealing with medical emergencies, and basic safety laws are some of the suggested topics.

E. Family Living

Activities here should stress understanding roles of family members, home management, household budgeting and family planning. In general, any activity that helps the student in learning how to deal with the family unit from a role that may be encountered, e.g. son, daughter, parent should be addressed.

F. Community Activities

Here, students need to learn the various resources available to them in the community. From there, the students should be urged to become involved in activities that they are interested in.

G. Recreational Activities

Continuation of junior high school goals and objectives should be stressed. Allowing the students to explore the various options afforded them and to pursue areas of interest are important at the secondary level.

H. Work Experience Placement

The work experience placement is the final step in the secondary program for the EMR students. It is here that they will learn the value of work. The placement is a crucial part of the student's transition from school to the working world and should be carefully planned and supervised. A good cooperative working relationship between school personnel and employers will ensure students' success on the job.

TRAINABLE MENTALLY RETARDED

Due to the nature of the TMR student, an educational program based on the traditional graded sequence (grades K-12) is usually not appropriate. Overall curriculum goals are stated in terms of the entire school experience of the student and programming to attain these goals is then briefly outlined.

We will also take this approach in discussing the teaching strategies for TMR students. Since programming for TMR students is usually accomplished in self contained classrooms by full-time specialists, relatively little time will be devoted to this topic area.

A. Program Goals

The general objectives of the program for a trainable student are: 1) developing self-care and self-help skills; 2) developing social adjustment skills for the home and neighborhood; 3) developing economic independence in the home or in a sheltered environment.

B. Elements of the Program

1. Modified Reading

In general, TMR students do not learn to read in any traditional form. Their "reading ability is limited to reading and recognizing their name, isolated words, phrases and common words used for their own protection (men, women, danger, etc.). In uncommon instances, some high functioning TMR students can learn to read.

2. Modified Mathematics

Trainable students can learn number concepts such as larger, smaller, less, more and so on. They can be taught to count up to ten (sometimes higher), tell time on a clock, and sometimes read a calendar. Some students have even been able to grasp fundamental money concepts.

3. Arts and Crafts

Activities in this part of the program should include projects by the students in woodworking, pasting and cutting, painting, drawing, coloring and needlework. Developing gross and fine motor control, as well as developing creativity would be the primary objectives of this area.

4. Physical Hygiene

Discussions of food eaten by students, care of teeth, personal hygiene, physical safety and posture would be ideal activities for this area. These habits should be developed both in the instructional setting and coordinated with the home environment.

5. Language Development

This program would stress the understanding of verbal concepts and the development of speech. Other areas such as listening skills, group discussions, singing and musical groups are also worthwhile activities.

6. Mental Development

Mental development can be stimulated by activity and exposure to many experiences. Development of the child's imagination, concept building, problem solving, and verbal and auditory discrimination are all part of this process.

7. Practical Arts

In this subject area we would find such activities as sewing, cooking, cleaning, dishwashing and basic food preparation. The thrust of this program would be proficiency in everyday household management skills.

8. Motor Development

Development of motor skills is stimulated by involving the student in games, indoor and outdoor recreation activities, and play-acting or drama related activities.

9. Self Help

Self help skills include such areas as grooming, toiletry, eating, dressing, washing and care of personal belongings. The general goal here would be proficiency in required daily activities.

10. Socialization

The socialization of the TMR individual would be best approached by having the students become familiar with certain skills to refine their interactions with others. Such things as greeting people with "hello", "how are you", learning acceptable table manners, being quiet while others speak and helping others would be goals for classroom activities.

LEARNING DISABLED

PREFACE

The term "Learning Disabilities" refers to a specific group of handicapped children. Because this is a relatively new field, there is no clear definition of this term.

The LD child has often been referred to as the child with a hidden handicap. Many times the milder forms of learning disabilities are easily mistaken for something else. The LD child is often normal in every respect except that his or her learning disability prevents regular progress in school. LD students can be found at all ages and grade levels. Most students have been identified during late primary and middle grades in school. The children with a learning disability see and hear things in a distorted fashion because the brain does not accurately perceive what they actually experience. In order for the child to have successful learning experiences, the individual must be taught through the strongest modalities. For example; if a student is having difficulty with auditory learning, a visual approach must be used.

Educational programs for LD students are more prevalent in the elementary schools than in the junior and senior high schools. There are an increasing number of adolescents being identified due to increased knowledge in the field and will require specialized programs that provide a continuation of service presently provided in the elementary schools. The more support LD students can get from parents and teachers, the better they will be able to cope with the daily frustrations.

A. DEFINITION

The National Advisory Committee for Handicapped Children (1968) provided a description of many LD children found in schools across the country.

"Children with specific learning disabilities exhibit a disorder in one or more of the basic psychological processes involved in understanding or in using written or spoken languages. These may be manifested in disorders of listening, thinking, talking, reading, writing, spelling, or arithmetic. They include conditions which may have been referred to as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, developmental aphasia, etc. They do not include learning problems which are due primarily to visual hearing, or motor handicaps, to mental retardation, emotional disturbance, or to environmental disadvantage."

B. CAUSES OF LEARNING DISABILITIES

Some factors that have been attributed to causing learning disabilities are:

1) Usually the child is a male. Boys account for 70% of all Learning Disabled students.

2) The child may be experiencing a developmental lag or slower rate of development than his peers of the same age.

3) Genetic background may be a factor. Research has shown that if this is explored, the child usually has had a brother, uncle or perhaps a father who had experienced difficulty in school.

4) Some Learning Disabilities are caused by serious pre-birth or post-birth accidents or illness. A fall or injury that has caused the child to lose consciousness, may be an example.

C. CHARACTERISTICS OF THE LEARNING DISABLED CHILD

(The LD child may have only one of these characteristics, but probably will have two or more)

1) Inadequate spoken language (may exhibit one or more speech problems) poor articulation, immature sentence structure, lisp or stuttering.

2) Reversal of letters (b for d). Confusion of the sequencing of letters in words (was for saw).

3) Frequent spelling errors: gross errors such as kint for night.

4) Usually cannot follow directions very well.

5) Confused by small print on pages.

6) Sometimes is awkward in gross and fine motor control.

7) Uncertainty of left or right handedness.

8) Short attention span.

9) Physically immature.

10) Poor written composition.

11) At times will appear to be rebellious with the teacher.

12) Unable to "explain" what they mean.

13) Lack of motivation.

14) Hypoactivity (not active enough).

15) Perseveration (repeats behavior).

16) Hyperactivity

It has been stated that there are many different behaviors all associated with LD. These are two characteristics that are universally found in these students:

1) Average or above average intelligence.

2) Underachievement in one or more academic areas.

D. IDENTIFICATION OF LEARNING DISABILITIES

The identification and referral of learning disabled children are almost always done by a regular classroom teacher. After the child has been referred to the evaluation team a series of assessment tools will be used to identify the students strengths and weaknesses. Evaluation should consist of evaluations in these areas: medical, psychoeducational, social and environmental. A medical/physical and history should be done by a pediatrician along with a hearing and vision examination to determine specific areas of disability. It is usually advisable for the school specialist responsible for the educational program to make a classroom observation of the student during or before the testing period so behavior can be observed. In order to provide an appropriate individual education program for each student, a complete assessment must be performed.

E. TYPES OF LEARNING DISABILITIES

Learning disabilities is a term that encompasses many different types of learning handicaps. These areas will be addressed in the following catagories:

1) Behavior
2) Perception
3) Motor
4) Language

1. Behavior disorders:
   a. Hyperactivity
      1) exhibits greater motor activity
      2) appears to be in constant motion
      3) movement is often involuntary
      4) taps foot or fingers and does not realize it
      5) social behaviors are often inappropriate

   b. Disorganization
      1) inadequate ability to organize thought processes and/or work
      2) poor spontaneity
      3) limited ability to plan ahead
      4) difficulty planning goals
      5) cannot organize incoming information and sequence thoughts

   c. Distractability
      1) cannot concentrate on specific tasks
      2) rapid changes in interest
      3) may have frequent mood swings and poor peer relationships
      4) performs poorly on motor tasks
      5) loses interest in abstract activities

d. Perseveration
   1) unable to alter behavior and attitude
   2) cannot shift from one activity to another when necessary
   3) adjusts poorly to new situations
   4) seems unable to alter the focus of attention

e. Emotional disorders
   1) destructiveness
   2) underachievement
   3) immature behavior especially during times of stress
   4) rapid changes in mood
   5) child may be frustrated most of the time

II. Perception:

a. Visual motor disability
   1) poor writing
   2) reversal of letters
   3) mixed dominance (confuses left and right hand)
   4) performs better on individual tests than on group pencil and paper tests
   5) may be hyperactive or easily distracted.

b. Auditory perceptual disability
   1) often has speech problems
   2) does not seem to understand speech
   3) may stare at the speaker
   4) follows written instructions better than verbal instructions

III. Motor

a. Balance
   1) may appear awkward
   2) bumps into objects, falls easily
   3) lacks preference in usage of hands
   4) holds writing utensils in an awkward manner

IV. Language
   1) may have limited or no speech
   2) lacks verbal concepts related to understanding directions
   3) poor sentence structure
   4) speech may be delayed
   5) has substitutions, omissions or distortions of consonant sounds in speech

F. TEACHING STRATEGIES

1. Behavior disorders

a. Hyperactivity:

1) Make a rule about movement in the classroom. Ignore children who do not follow the rules.
2) Move the child's desk away from children with whom the child talks.
3) Praise the child for good behavior and following the rules.

b. Disorganization:

1) Simplify all classroom directions. Give each task as a separate direction, and praise the child for completion of each separate task.
2) Record assignments on a tape recorder. Allow the child to listen to all directions.
3) Record the student's rate of work (problems completed per minute) and have students plot their rate at the end of each period.

c. Distractibility:

1) Make all tasks more interesting by giving directions in an unusual way or allowing student to respond in a novel fashion (have child print out answers to mathematic problems, give directions to students using tapes).
2) Place the student's desk in an area of the room where environmental stimuli (windows, blackboard, posters, etc.) are at a minimum.
3) When possible, assign another student as a peer tutor to work directly with the distractible student.

e. Emotional disorders:

1) For each paper completed and not mutilated or defaced, allow the student a brief period for creative activity.
2) Present the child with alternative tasks that have similiar learning goals. This will minimize frustration.
3) When the student misbehaves in class and is reinforced by peers, reprimand not only the student, but those who are influencing the behavior of the child.

II. Perception

a. A Visual motor disorder:

1) Have the students practice various gross motor skills (i.e. walking, running, skipping rope) in order to assess the degree of the problem.
2) Provide activities which require the students to give verbal directional responses to the question asked. (i.e. We are fifteen feet to the left of the door. The students have to respond to where they are in relation to the door).
3) Have the student trace and then independently write the letters of the alphabet. Sandpaper letters may be used for part of this activity.

b. Auditory perceptual disability:

1) Have the students close their eyes and identify various environmental sounds (cars, train noises, etc.).
2) Have the students identify classmates when they have only heard their voices in the classroom. This can be done by separating students or having them turn their backs.
3) Using a device to reproduce noise (whistle, drumsticks, etc.) have students locate the direction of the sound. Students should close their eyes while the teacher moves around the room.

III. Motor Disabilities

1) Have students cut on various lines using a pair of scissors. As the students become proficient, increase the difficulty of the activity.
2) Create an obstacle course which will allow students to climb up, over and around. This will develop gross motor skills in younger children.
3) Provide eye-hand activities (games) for students such as jacks, twister, pegboard, etc.

IV. Language Disabilities

1) Develop activities that require students to speak and listen to peers (i.e. show and tell, class discussion etc.).
2) Read a story aloud to the class. Have students answer questions to develop better listening and comprehension skills.
3) Have students listen to grammatically incorrect sentences. Have them identify what is incorrect in the sentences and have them rectify the errors.

4) Provide a series of creative writing skills which will help to improve written language disabilities. Language Experience stories would be an example.
5) Provide the student with a list of letters that have similiar configurations. Say a letter and have a student circle the correct letter on the sheet of paper.

EMOTIONALLY DISTURBED

Preface

Emotional disturbance is the least defined and understood of all the handicaps or disorders mentioned in this booklet. As stated in the following definition, it encompasses many emotional conditions. These conditions, characteristics and teaching strategies will vary greatly from individual to individual.

A. DEFINITION

"Emotional disturbance" is a general term that is used to include numerous imprecisely defined conditions such as "mental illness", "psychosis", "neurosis" and "phobia".

An emotional disorder or disturbance is basically a deviation from age-appropriate behavior which significantly interferes with: 1) the child's own growth and development and/or 2) the lives of other people. (Kirk, p. 389)

Fundamentally, children who are identified as emotionally disturbed, exhibit excessively aggressive and inappropriate behavior.

B. CHARACTERISTICS OF THE EMOTIONALLY DISTURBED

Many studies have been done to determine common characteristics of emotionally disturbed children. Emotionally disturbed children are characterized by inner tensions and anxiety and often display neurotic and psychotic behavior.

According to a recent study, characteristics of emotionally disturbed children were generalized to be these:

1) Of the group 83% were boys, 17% girls.

2) The I.Q. range was 68 to 132, with the majority of the students scoring over 100.

3) More than half of the clients were classified as neurotic, with acting out behaviors as a primary problem.

As you can see, these results are broad and imprecise at best.

Another listing of characteristics by a California Education Department is slightly more precise. The study concluded that the emotionally handicapped were: 1) seriously below average in school achievement; 2) sent to the vice-principal more often for disciplinary action; 3) more often dropped from school or left school; 4) more often absent from school without excuses; 5) more frequently sent to the health department for illness, need of rest, or discomfort; 6) more often served by school counselors; 7) more often the subject of home calls by child welfare workers and attendance officers; 8) subject to more contacts with police; 9) more likely to be on probation; 10) found more frequently to commit penal and vehicle code violations; 11) more frequently referred to local guidance clinics.

C. TEACHING STRATEGIES FOR EMOTIONALLY DISTURBED STUDENTS

A. teacher may believe that rewards should not be given to students because he/she considers them bribes. But these rewards are bribes only in the sense that an adult's salary is a bribe. They tell students that their efforts have value and that their work is considered worthy of tangible compensation.

Therefore, it is advisable that when working with emotionally disturbed students, some type of systematic, predictable reward structure be set up in the classroom. There are many different systems, but in general the following ground rules should be adhered to:

1) Rewards should immediately follow the required behavior.

2) Rewards should be earned by small increases in quality or quantity of work.

3) The student should be able to earn them frequently.

In general terms, an educational setting involving the emotionally disturbed child should follow these basic principles:

1) Each child needs to start at his own particular level.

2) The teacher must set up definite goals and objectives for the program as well as each individual.

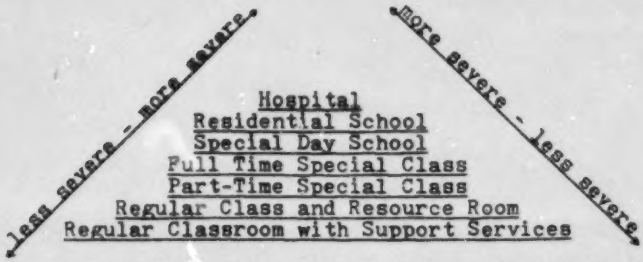
3) The student must be aware of these goals and objectives.

4) The child needs to proceed in a step by step progression.

5) The teacher must continually monitor the child's progress, provide immediate feedback and give rewards.

6) The teacher must be systematic in the teaching approach.

Children with emotional disorders vary in their needs for special services. Kirk (1972) presents a chart that provides us with some idea as to range and types of special services offered for these students.



The following is a brief explanation of the services mentioned in the chart and what type of students are best served in each area.

1) Regular Classes

The regular classroom situation handles a great number of disturbed students. These children usually have minor problems and perform better with the role models offered in the mainstream of education. In this situation, the teacher is supported with consultations from the resource room teacher.

2) Regular Class and Resource Room

In this situation, the child is assigned to a regular class, but spends part of the day in the resource room. In the resource room, the child receives remedial work in his other subjects and is in contact with a teacher for specialized instruction or consultation.

3) Part Time Special Class

The part time special class enrolls the student into a special class, but places him into regular classes where he/she can participate on an equal basis with his/her classmates. Such classes may include physical education, art and music.

4) Full Time Special Class

The full time special class is primarily for students who, because of their emotional disorders, cannot function in a regular classroom environment. The total program of the child is administered through a special class for the emotionally disturbed in the public school building.

5) The Special Day School

The special day school is usually a facility for children who could not benefit from any of the services offered in the public schools. These schools usually enroll a large number of children with behavioral disorders. Here the children live at home and commute to the facility daily.

6) Residential School

The residential school is reserved for those children who are unable to function in the community or public school. They require twenty-four hour a day supervision in educational services and daily living management skills.

7) Psychiatric Hospital

The psychiatric hospital is planned for the very severely emotionally disturbed child who requires medical and psychiatric supervision.

Checklist of Emotional Disturbance Indicators
(Kirk, 1972)

1. Shows dislike of school._____
2. Resents restriction and school regulations._____
3. Is failing most subjects._____
4. Has repeated one or more grades._____
5. Has attended a number of different schools._____
6. Expects to leave school as soon as the law permits._____
7. Is disruptive to school property and other persons._____
8. Does not participate in extra curricular activities._____
9. Displays temper tantrums._____
10. Has only vague academic or career plans._____

VISUALLY IMPAIRED

Preface

The visually impaired child has lost, to some degree, the most necessary tool required in traditional education today - sight. Educational procedures today rely heavily on the sense of vision. Blackboards, films and slides are a major part of classroom instruction. The printed word is an integral part of any learning situation. The horizons of the visually impaired student are as boundless as any other person his age. It is the pathways to these horizons that are altered by roadblocks and detours.

We will try to give you some sense of what detours are available to the classroom teacher. In general, most visually impaired students require some services from a vision specialist to assure proper educational programming and instructional methods for the students. The American Optometric Association (1976) offers some valuable information for teachers concerning the visually impaired.

A. DEFINITION

There are many terms and definitions in the area of visual impairments. To remain brief, we will define two major areas in this area: blindness and partially sighted.

Blindness is generally defined as visual acuity for distance vision of 20/200 or less in the better eye with the best correction. That is to say that the person defined as blind with his corrective lenses on (glasses, contact lenses, etc.) must be 20 feet away from an object to see the object as well as a normal person (20/20 vision) sees the object from 200 feet. (Kirk - 1972 p. 292).

It should be noted that in the definition for legal blindness, a field restriction is also an important aspect. We will not address this issue as its major implications reside in the area of mobility and independent travel.

The partially sighted student is defined as a student whose visual acuity is better than 20/200 but not greater than 20/70 in the better eye with correction. That is, a person blind in one eye and 20/70 in the other eye when wearing glasses is classified as partially sighted. (Kirk, p. 292).

B. LEARNING CHARACTERISTICS

The learning characteristics of a visually impaired student are usually no different than those of a regular student. The intellectual capacity is not affected by vision. Perception of facts and learning pathways in the brain are no less developed than those of sighted peers. The problem here is input. Input of information must go through other channels than sight. If the student is partially sighted, a good deal of learning may occur through the visual mode. However, when blindness is total (no light perception) the entire visual road to learning is blocked. It is time to implement alternative strategies.

There are certain cases where a student may have a secondary handicap along with a vision problem. For instance, a student may be visually impaired and learning disabled. In these instances, a judgement must be made as to which handicap is the major roadblock to normal learning. This is a decision best left to a specialist.

For our purposes, let us look at how to deal with a vision problem in the regular classroom.

C. TEACHING STRATEGIES

Since vision problems arise in children in all grades of instruction, our discussion of teaching strategies will not be broken down into a graded approach. It is safe to assume that the techniques discussed here are appropriate for any visually impaired student regardless of age.

Some children may need only a few of the adaptive techniques listed below. Other students may require a combination approach. These devices are appropriate for certain students with specific vision problems and should be utilized only after consultation with a vision specialist.

1. Visual Aids

1) Bookstands - These help to reduce postural fatigue by bringing the work closer to the student's eyes. One can also use other books stacked behind the book being read to achieve the same effect.

2) Felt tip pens - Preferable in black, with varying widths, these produce a bold letter and help the student distinguish important parts of written material and notes.

3) Acetate paper - (Also used for overhead transparencies), preferred in yellow, acetate paper will tend to darken the printed material on a page as well as heighten the background of the paper.

4) Additional lighting - Lamps are also used to provide variable intensities of light for additional or dimmed illumination of the printed surface.

5) Large type books - For children who cannot read regular print, the quality, spacing, and typeface are all variable factors in different large print books.

6) Bold line paper - For students who find it hard to see the lines on regular paper, bold line paper is available.

7) Page markers and reading windows - These may be helpful for students who have trouble focusing on a page or a single printed word.

8) Sun visors and shields - Some children are photophobic (sensitive to light) and require some help in blocking out high quantities of light and glare from the environment.

2. Tactual Aids

1) Braillewriter, stylus and slate - A braillewriter is a manually operated six key machine that produces printed braille. It works much like a typewriter. The slate and stylus are carried around in the pocket and can also be used to print braille. These allow the student to take notes quietly (unfortunately, the braillewriter also is as loud as a typewriter) and not have to carry around a heavy machine all day.

2) Abacus - Some teachers are now instructing their students in the use of the Cramner Abacus, especially adapted for the blind student.

3) Raised line paper - This allows the child to write script "on the line" using raised lines on the surface of the paper.

4) Templates and writing guides - Made of cardboard, plastic or metal, these open rectangular forms allow blind people to write their names or other information within assigned boundaries. These are quite popular for signing documents.

3. Auditory Aids

1) Cassette Tape Recorders - May be used to take notes, listen to recorded texts or put together writing assignments.

2) Talking books - The Library of Congress (Talking Book Program) and other organizations offer free reading services for the visually impaired and blind population. Cassette tapes and the special machines (adapted for use by the blind) are all available free.

3) Speech Compressors - These machines speed up recorded material without altering the pitch of the recording.

4. Electronic Aids

1) Talking calculator - Hand held, this device mechanically reproduces speech which allows the student to hear all entries and results.

2) Optacon - This machine is an optical-tactile converter. It transforms print into raised letters configurations that are read tactily by the reader.

3) Closed circuit television - This enlarges an image or print onto a T. V. screen for the visually impaired student.

5. Classroom Instruction Aids

Demonstrations in class

Try not to stand with your back to a window. Glare will bring on eye fatique easily (true for non-visually impaired students also).

Allow the visually impaired student to stand to the side of or next to the demonstration.

Allow child to assist you in the demonstration or to handle the materials used in the demonstration beforehand.

Uses of Chalkboard

Front row center is usually the best physical placement for the visually impaired student.

Have carbon copies of the notes for the child to read at his seat.

Read notes aloud as you are writing them.

Lend notes in advance to vision consultant for Brailling or enlarging procedures (when appropriate).

Maps and Charts

Allow child to move closer if desired.

Provide a desk copy of the map or chart.

Allow itinerant teacher to enlarge material if time allows.

Filmstrips and Movies

Again, allow child to sit in comfortable range of the screen.

If there are subtitles, read them for the class.

Rear screen projectors are especially good as they allow the child to sit directly in front of the screen.

CHECKLIST FOR IDENTIFICATION OF VISUALLY IMPAIRED STUDENTS

This list can be used to indicate to the parents, school nurse or practitioner the need for a vision examination. One check should be recorded for signs occurring occasionally. Two checks are to be recorded for those signs occurring frequently.

Appearance of the Eyes

Eyes crossed at any time	____	____
Reddened eyes	____	____
Watering eyes	____	____
Encrusted eyes	____	____
Frequent styes	____	____

Behavioral Indications

Body rigidity while looking at distant objects	____	____
Thrusting head backwards or forwards while looking at objects	____	____
Avoiding close work	____	____
Short attention span	____	____
Daydreaming	____	____
Turning head so as to use only one eye	____	____
Placing head close to book (nose reading) wher reading or writing	____	____
Frowning or scowling while reading or writing	____	____
Excessive blinking	____	____
Rubbing eyes frequently	____	____
Closing or covering eyes	____	____
Disliking visual tasks	____	____

Displaying fatigue after a visual task	____	____
Losing place while reading	____	____
Using finger while reading	____	____
Saying words aloud or lip reading	____	____
Moving head rather than eyes while reading	____	____
Difficulty remembering what was read	____	____
Persistent reversals after second grade	____	____
Confusion of similar words	____	____
Poor eye-hand coordination	____	____
Unusual awkwardness	____	____
<u>Complaints by the Student</u>		
Headaches	____	____
Nausea or dizziness	____	____
Burning or itching eyes	____	____
Blurring of vision at any time	____	____

Hearing Impaired

Preface

It is estimated that at least 5% of all school age children have hearing levels outside the normal range. It is also widely accepted that one or two out of every ten in this group require some form of special services, (Silverman and Lane 1970).

The U.S. Office of Education estimates that one half of one percent of school age children are deaf or hard of hearing.

As with the visually impaired student, a hearing impaired child may have other educational handicapping conditions besides a hearing loss. Here again we will address the hearing impaired student as being educationally impaired due to a hearing loss. When two handicapping conditions occur, the more prevalent one must be identified and addressed as the child's main education problem.

A. DEFINITION

The degree or amount of hearing loss is usually measured in decibels (db). The instrument used in this measurement is called an audiometer and this evaluation is done by a hearing specialist (audiologist) or school nurse. Smith and Neisworth (1975) offer suggestions for working with hearing impaired students.

The following classifications of auditory impairments are widely accepted among present educators.

Deaf - Hearing loss is so severe that the sense of hearing is non-functional and the development of normal spoken language is prevented.

Hard of hearing/partially hearing - The sense of hearing is defective but functional. The development of spoken language is not precluded. There are five levels of partial hearing with varying degrees of decibel loss.

Slight:	27-40 db loss
Mild:	41-55 db loss
Moderate:	56-70 db loss
Severe:	71-90 db loss
Extreme:	91 or more db loss

B. LEARNING CHARACTERISTICS

The specific learning characteristics of the hearing impaired student are usually no different from those of the regular student. As with the visually impaired student, the learning difficulty is not processing information, but receiving it. Therefore, the classroom teacher should be more concerned with adaptive materials and presentations in order to circumnavigate the child's hearing impairment.

In the case of the totally deaf student, there are two main options. One is mainstreaming the child and using an interpreter to sign verbal presentations to the student. The other approach is a separate classroom for the hearing impaired. Some states also provide a residential school for the deaf in severe cases of hearing loss and educational handicaps.

C. TEACHING STRATEGIES

As with the visually impaired, our approach to developing strategies will not be grade oriented. We feel that these adaptive techniques will be useful with many hearing impaired students regardless of their academic grade.

In this section, we will stress the importance of adapting techniques for your classroom style. To deal with the hearing impaired student is to deal primarily with an informational input problem. And if there is trouble "inputting" information, it stands to reason that the child will also have trouble in "outputting" information (speech).

Therefore, let us now spend some time on some of the ways you can deal with the hearing impaired student in your classroom.

1) General Techniques

Try to talk facing the child in the classroom. Do not face towards the board or walk around the classroom constantly as this will make your voice appear to change in pitch and volume.

Do not repeat a question word for word if the child does not understand it at first. Try rephrasing the question as this will supply a different set of words that may be more easily read from your lips.

Speak in a moderate tone. Do not try to emphasize (mouth) your words as this will distort the normal rhythm of your voice. A good lipreading student will be able to understand your messages without great changes in your speaking routine.

2) Classroom Assignments

Have the student check verbally presented assignments at the end of period with your written notes of the lesson.

Write assignments on the board as you dictate them to the class. This is a good practice for all students.

In group discussions, allow the hearing impaired student to sit off to the side rather than directly in front of the group. A profile approach will allow the student to lipread much more effectively than if he were head on with other participants.

During oral reading exercises, have the child look on with another student. A piece of paper or card to aid in following the sentences of the reading is advisable.

Give a piece of carbon paper to a neat note-taker in your class. After the class, the set of carbon notes can be used by the hearing impaired child to compare with that individual's notes. This will allow you to see what general items the child is missing in your presentation and allow for improvement by you and the student.

Do not give directions to the class while the students are reading or looking down at something on their desks. The hearing impaired child must be able to <u>see</u> what you are saying.

Aid the child by previewing the type of remark you are going to make. If you are going to ask a question orally to the class, put a large question mark on the board before you ask the question. This will serve to warn the child that a question is coming up.

Try to review vocabulary words with the student before they are presented in class. This may be accomplished by allowing the student to take the list home and work on it with a parent. It is very important to build word knowledge and comprehension skills for any student, but even more important with the hearing impaired.

3) <u>MECHANICAL TEACHING AID</u>

An overhead projector is highly advisable as it keeps the student in one visual area and allows your face to be lighted (for lipreading) from refracted light off the screen and writing stage of the projector.

A tape recorder in the class will allow the parent(s) of the child to know what is being taught in the classroom and inform them of homework assignments that are due.

When showing filmstrips, allow another student to work the projector while you stand in front of the class to make important points clear for the class.

The hearing aid amplifies sound for the child. It is advisable that environmental noise be kept to a minimum. A constantly noisy classroom can be very irritating to a student with a hearing aid. Also, it is usually a good idea to check the volume control of the hearing aid, especially with younger students who occasionally need to be reminded.

IDENTIFICATION CHECKLIST

one check = occasionally
two checks = usually

Restless behavior when instruction is primarily oral	___	___
Turning head while listening	___	___
Talking loudly	___	___
Sensitive to loud sounds	___	___
Difficulty understanding when there is background noise	___	___
Difficulty understanding when in groups	___	___
Social immaturity	___	___
Frustration and withdrawal	___	___
Delayed or retarded speech functions	___	___
Watches speaker's face carefully	___	___
Speech articulation difficulties	___	___
Cupping hand to ear	___	___
Easily distracted by background noises	___	___
Often "hushes" students around him	___	___
Displays need to have volume set high on T.V., radio and audio presentations	___	___
Doesn't follow orally presented directions and presentations	___	___
Seems depressed and sullen	___	___
Understands better when speaker's face is visible	___	___
Consistently asks for repetitions	___	___

ORTHOPEDICALLY HANDICAPPED

Preface

A child whose motor abilities are impaired is said to be orthopedically handicapped. An example of an orthopedically handicapped student would be one who has lost a limb from an auto accident or from a birth defect. They may need a special prosthetic aid in order to travel around school and may need special services in the areas of occupational therapy and adaptive physical education.

In general, these types of students are not educationally handicapped. They have no real learning problems. The orthopedically handicapped student learns to read, write and spell by the same methods and at the same rate as other children. Occasionally emotional problems arise because of the student's appearance or individual frustrations. But, mainly, we are concerned with physical adaptations to the classroom and school building when we provide a program for the orthopedically handicapped student.

A. DEFINITION

The orthopedically handicapped student is a child who has a crippling impairment which interferes with the normal functions of the bones, joints or muscles to such an extent that special arrangements must be made by the public school (Kirk, 1972, p. 367).

Included in this area of orthopedically handicapped students are students who are born with handicaps and students who become orthopedically handicapped later in life (accident, disease).

The children who are born with birth defects are usually victims of an inherited trait or a defect during pre-natal development. These types of defects would include absence of limbs, club feet, and spina bifida (a defect in the closure of the rear wall of the spinal cord resulting in abnormalities in the spinal cord).

Other children acquire their handicapping conditions after birth, through accidents and infectious diseases. Some of the more common orthopedically handicapping diseases would be: arthritis, muscular dystrophy, infantile paralysis (poliomyelitis) and osteomyelitis (bone inflamation).

B. LEARNING CHARACTERISTICS

Once again, with the orthopedically handicapped individual we are not faced with a student whose learning styles are any different than any other student of the same age. We are, however, faced with the problem of physical adaptation of the classroom and learning environment.

This will be the main subject area of the following section. How to make physical adaptations to your curriculum, materials, classroom and school building to meet the specific needs of the orthopedically handicapped student.

C. TEACHING STRATEGIES

In general, provisions made for the orthopedically handicapped student are made for physical, medical and health reasons. The adjustments made by the student are physical and sometimes emotional. If the student is unable to hold a book or to write because of a physical handicap, it becomes necessary to develop devices which will facilitate the holding of the book or communicating through pen and paper. Some of the special adaptations for the orthopedically handicapped student are listed below:

1) School Building Adaptations

Ramps, wide hallways, railings on stairways and hallways, lavatories with widened stalls and handrails, doorways wide enough for wheelchairs and non-skid floor surfaces, are just a few of the many physical adaptations that must be made for the orthopedically handicapped student within the school building.

2) Adaptive Special Equipment

In addition to adaptations made in the school building environment, the teacher must make use of aids and devices for instructional purposes.

All of these devices are designed for specific disabilities and must be used on an individually oriented basis. A few adaptive devices are listed below. It must be stressed that choosing which device to use with a particular student is the job of a trained occupational therapist, physical therapist or school nurse.

Bookracks - holds books erect and at stable distance.

Ceiling projectors - used for bedridden students.

Automatic page turner - used with rack, for children lacking gross-motor control required to turn a page.

Motorized wheelchairs - for students unable to use manual wheelchairs.

Cut out table - fits on to the front of wheelchair and allows student to work directly in front of the wheelchair.

DEVELOPMENTAL DISABILITIES

Preface

This term refers to a multitude of different handicapping conditions. Since mental retardation is one of these conditions, the reader may wonder why it was not included in this section. Since mental retardation is one of the more prevalent handicapping conditions within the developmental disabilities group, it was thought that an entire section (pages 1 to 12) should be devoted to this area. The remainder of the handicapping conditions, though important, were grouped together in this section as they are not as common in the everyday school population. A definition of each disability is provided by Hammer and Richman (1975).

A. DEFINITION

The term developmental disability refers to a disability attributable to mental retardation, cerebral palsy, epilepsy, or any other neurological condition which has continually or can be expected to continue indefinitely, and which constitutes a substantial handicap to such individuals.

1) Epilepsy - Refers to a group of neurological conditions called convulsive disorders. It is characterized by abnormal chemical/electrical discharges from damaged nerve cells in the brain. Seizure activity will vary according to the location and amount of discharge from the brain.

2) Cerebral Palsy - is a general term applied to a group of permanently disabling symptoms resulting from brain damage. It is characterized by awkward or involuntary movement, poor balance, irregular gait, and tightness of the muscles. There are several types of Cerebral Palsy, the most common being Spastic Cerebral Palsy (tightness of the muscle) and athetosis (slow recurring involuntary movement of the arms and legs).

3) Autism - a term for severe disturbance of mental and emotional development. It usually appears in young children. It is a profoundly handicapping disturbance that is based in the neurological organization of the individual and is believed to be partially caused by an impairment of the central nervous system.

Note: Since these handicaps are more medically oriented than others, teaching strategies and learning characteristics will vary greatly according to the severity of the degree of affliction. Students with Cerebral Palsy in most cases have normal intellectual abilities. Their disability requires more medical needs than educational. Autism, however, is a severe neurological impairment that requires specific teaching strategies that emphasize developmental activities, self help skills, behavior management, language development as well as social interaction and play activities.

CHILD ABUSE AND NEGLECT

A. PREFACE

The neglect and abuse of children has been evidenced since the beginning of time. Infanticide, the killing of newborn infants by suffocation, drowning or exposure to the elements, was accepted by previous societies, particularly in the seventeenth century. In some societies, it was a regular practice to destroy all physically handicapped babies. With the advances in medicine, the special needs of children during the nineteenth and early twentieth centuries have been recognized. We are aware of the high incidence of child abuse and neglect in our modern day society. A great number of cases of mistreated children are not being reported and are going unrecognized and undetected. These children are left unprotected from their abusers. Recent statistics show that over one million children were abused in the United States in 1979. Over 2,000 of them died.

B. DEFINITIONS

1) Child Abuse - Any physical or emotional injury or injuries sustained by a child as a result of a malicious act by a parent, or other person who has permanent or temporary care, custody or responsibility for the supervision of a minor.

2) Neglect - The failure of a parent or guardian to provide a child proper subsistence, education, medical or surgical care or other care necessary for his/her health, morals, or well being, or if the parent allows the child to exist in a situation or surroundings that may prove injurious.

C. GUIDELINES FOR SCHOOL PERSONNEL

Suspected child abuse or neglect must be reported to the Bureau of Child and Family Services, Division of Welfare, immediately. Such cases should be referred also to a team within each school immediately to determine if the child has been abused in a "reportable" sense, or has been "neglected" by parents intentionally. Emergencies should be managed by the school nurse, as other injuries are.

Reporting guidelines for school personnel, regarding suspected child abuse and neglect are available from most school districts in New Hampshire. The Portsmouth School Department for example, has made an effort to distribute such guidelines to all teachers.

D. CHARACTERISTICS OF ABUSIVE/NEGLECTING PARENT

1) Parent was an abused child.
2) "Stress factors" exist within home, i.e. financial, marital problems, alchol-drug abuse, overcrowded housing, etc.
3) Unwanted pregnancy; angry about pregnancy, lack of prenatal care.
4) Ignorant of child development; expects too much too soon from child.
5) Poor self-image, low self-esteem.
6) Low frustration level.
7) Isolated geographically and emotionally.
8) Sexual abuse-patriarchial family sets strict rules and standards, chooses friends, clothes, etc.
9) Marital problems - spouse tends to be passive, less-educated, isolated, married young.

E. CHARACTERISTICS OF ABUSED CHILD

1) Frequent injuries, i.e. bruises, welts, burns, etc.
2) Explanations of cause not compatible with injury.
3) Frequent absences from school.
4) Denies abuse, protects parents.

F. Characteristics of neglected child

1) Lack of appropriate food, clothing, shelter and medical care.
2) Lack of supervision.
3) Academic problems.
4) Delinquent behavior - "acting out".
5) Notably below normal developmental stages, i.e. failure to thrive.

G. TYPES OF INJURIES FOUND IN PHYSICALLY ABUSED CHILDREN

1) Bruises, welts
2) Burns, scalding
3) Bone fractures, (excluding skull)
4) Wounds, cuts, punctures
5) Malnutrition (deliberately inflicted)
6) Sprains, dislocations

H. BEHAVIORAL INDICATORS

1) Are wary of physical contact by parents or anyone else.
2) Do not look to parents for assurance.

I. INDICATORS FOR EDUCATORS

1. In the Classroom

a) A disruptive or aggressive child may reflect or be imitative of destructive behavior in the home.

b) A withdrawn or quiet child may be a product of a similar home environment.

c) Poor attendance or chronic lateness can be indicative of an adjustment problem in the home which affects the child.

d) A child coming to school without breakfast is not necessarily neglected. But a child who continually comes to school hungry may very well be.

e) Observe the child's clothing and cleanliness. Old clothing, if clean and in good repair, may indicate an economically struggling, but emotionally supportive home. Clothing that is torn and dirty may indicate a poorly organized or disruptive home life. An unclean child may reflect a lack of routine resulting from a breakdown in household management.

f) Of special importance may be a significant change in the child's attitude of behavior in school.

g) Very often, a special child in a family may be singled out for abusive treatment. A slow or retarded child or an emotionally disturbed child who demands special actions from his parents may also receive the brunt of their rage or frustrations. Equally so, an emotionally disturbed child or brain damaged child may already have been the recipient of such deprivations.

2. In The Nurse's Office

a) Malnourishment

b) Frequent complaint of pain without apparent injury may indicate a child's attempt to cry out for help without directly betraying his parents.

c) Lack of necessary or appropriate medical attention. Often, drugstore remedies are substituted for medical care in neglect or abuse situations.

d) The child who is constantly tired in school may reflect a lack of routine in the home or a disruption in the home.

e) Most obvious of all, does the child frequently have severe bruises or welts or inexplicable physical injuries?

J. HIGH RISK FAMILY FOR POSSIBLE CHILD ABUSE AND NEGLECT

1) Observation Checklist

a) Over concern with baby's sex

b) Over concern with baby's performance

c) Worried that he/she won't meet standards.

d) Depression over pregnancy

e) Mother frightened and alone

f) Lack of support from spouse

g) Living area, friends, telephone, neighbors, are they isolated?

h) Disappointed with child's sex

i) Does the mother see the child as demanding?

j) Do the parents complain about the child?

k) Can she comfort the baby when he/she cries.

l) Are there sibling rivalry problems?

m) Family reaction to the baby

n) Is husband more than normally jealous?

2) Positive Characteristics

a) Parents see likable activities of infant; see infant as an individual initially

b) Baby is healthy

c) Baby is not too disruptive of parents' life style

d) Each parent can care for infant during a crisis

e) Stable marriage

f) Parents have good friends or relatives close by; sound, need-meeting system

g) Parents have coping abilities; to be able to drive or get transportation, etc.

h) Parents in good health

i) Parents had helpful and good role models in growing up

j) Parents can have fun together; hobbies

k) Father supports the mother in care of the baby

K. SEXUAL ABUSE

Indications of sexual abuse

MEDICAL (PHYSICAL) INDICATORS

1) Bruises in external genitalia, vagina or anal regions

2) Bleeding from external genitalia, vagina or anal regions

3) Swollen or red cervix, or-vulva

4) Positive tests for any of the following:

   a. gonococcus
   b. spermatozoa
   c. pregnancy
   d. venereal disease

BEHAVIORAL INDICATORS

1) Regressive behavior - molested children (especially younger children) may withdraw into fantasy worlds. Sometimes these children give the impression of being retarded when, in fact, they are not.

2) Delinquent or Aggressive Behavior - molested children (especially pre-teen and teen) often act out their anger and hostility on others.

3) Confiding in someone - a molested girl may confide in a special friend or teacher. These confidences may not take the form of direct information about being molested, but may involve such statements as "I'm afraid to go home tonight", "I want to come and live with you", "I want to go and live in a foster home."

4) Poor peer relationships - molested children (if molestation had occurred over a long period of time) may not have social skills or are too emotionally disturbed to form peer relationships. The parent(s) have a vested interest in keeping them emotionally isolated. The child may have such a poor self image (the "bad me" concept) that it overshadows his/her whole existence.

5) Unwillingness to participate in physical/ recreational activities - young children who have been highly sexually stimulated or have been forced to have sexual intercourse with an adult, may find it painful to sit in their chairs in school, or to play games which require a great deal of movement.

6) Runaways - teenagers who have been molested sometimes resort to escape and run away from the home.

H. REPORTING SUSPECTED CHILD ABUSE AND NEGLECT

The Division of Welfare has adopted policies and procedures for schools enabling them to report any suspected cases of abuse or neglect.

Who Shall Report

All school officials, teachers, school nurses and guidance counselors are legally responsible for reporting any suspected cases of child abuse and neglect.

Those, who in good faith make a report of suspected child abuse or neglect have immunity from any liabilities, civil or criminal. Further information concerning welfare guidelines may be obtained by contacting the Bureau of Child and Family Services in New Hampshire at 603-271-2522.

UNIT 3 STUDENT ASSESSMENT AND EVALUATION

A. PREFACE

The discipline of student assessment in today's educational world is complicated and requires the training of experienced specialists in order to serve its intended purpose.

Although specialists are the ones who usually administer and score these tests, the duty of interpretation many times falls upon the classroom teacher. This is the primary reason for our interest in entering some basic information on the subject of educational assessment in this booklet.

First, we must differentiate between the terms testing and assessment. Testing is but one part of a larger area called assessment. One can test without assessing. Assessment is a multifaceted process that involves far more than just administering a test. It involves selecting the appropriate test, interpreting results and determining how these results will affect the prognosis of the student and the individual educational plan.

With these thoughts in mind, we can divide assessment into two major categories; formal assessment and informal assessment.

B. FORMAL ASSESSMENT

The purpose of formal assessment is to provide scientifically based information that will allow for intelligent decisions about an individual's specialized program. This information is gathered by choosing an appropriate, standard normed test to administer to the student. These types of tests have been tested in the field in all parts of the country and have a proven reliability. A sample of some of the tests are listed below.

Selecting evaluative tests is not easy. Many factors such as the student's ability, information needed, time allowed and physical testing environment must be considered. In short, different tests evaluate different children in different ways. It is not our goal to make the reader proficient in selecting or administering formal assessment tools. These are tasks for trained specialists located in most schools. We are more concerned with offering some background information on some of the more popular tests used with students today. This, we hope, will allow you to deal with interpreting a specific test score or reviewing someone's interpretation when the time arises. It is suggested that for a more detailed interpretation of any student's evaluation, the classroom teacher should talk with a testing specialist, such as a school psychologist, Special Education teacher, or in some cases a guidance counselor who may be responsible for evaluating students.

C. INFORMAL ASSESSMENT

The classroom is the best place to identify problems in children. Teachers are constantly observing students. Different children exhibit different characteristics. It is important for the classroom teacher to gain a realistic perspective of the individual's learning, behavior and personality. The teacher should consider these variables, as they observe an individual, 1) specifically, what is the problem? 2) how often, and when does the problem occur? 3) What is the environment like when the problem occurs? It is usually helpful for parents and teachers to work very closely to determine whether the behavior is isolated or is occurring at home as well as in the school setting. Family problems have contributed to changes in more than one student's behavior. Many effective assessment tools found in schools today are developed by regular classroom teachers (i.e. checklists, narratives .

D. ASSESSMENT OF READINESS FOR KINDERGARTEN OR INITIAL READING INSTRUCTIONS

1) The Handbook of Special Education (1975) provides descriptions of some assessment and evaluation techniques.

a) ABC Inventory to Determine Kindergarten and School Readiness

Entrants to K & grade 1; 10-15 minutes

Four tasks; draw a man, answer questions that reveal the characteristics of common objects, general knowledge, and simple tasks involving numbers and shapes.

b) Denver Developmental Screening Test

Preschool to 6 years; 15-20 minutes

105 most discriminating items taken from other developmental scales and standardized on 1036 Denver children.

c) First Grade Screening Test

First grade entrants; 30-45 minutes

Twenty seven items used in an attempt to identify children with central nervous system dysfunction, intellectual deficiency, or emotional problems.

d) Gates-McGinitie Readiness Skills

K & Grade 1; 120 minutes

Eight measures of prereading skills. Norms based on 4500 children from 35 communities.

E. INTELLECTUAL FUNCTIONING

1) Wechsler Intelligence Scale for Children (WISC)

The WISC is an individual intelligence test which is designed for subjects from 5-0 years to 15-11 years of age. The test measures a comprehensive kind of intelligence that involves traditional intelligence task problem solving, but also the measurement of thought process, personality, and learning strengths and weaknesses. The WISC is organized in terms of six verbal subtests and six performance subtests yielding a verbal and performance I.Q. These two I.Q. numbers are computed using a special procedure by a qualified examiner which produces a full scale I.Q. for the individual.

2) Wechsler Intelligence Scale for Children-Revised (WISC-R)

Same test as above revised in 1974 based on the 1970 Census of 1100 males and 1100 females. The WISC-R alternates verbal and performance subtests. This is done to facilitate interest on the part of the examinee. Similar in philosophy and mechanics to the WISC. Some of the subtest questions are different.

3) Wechsler Adult Intelligence Scale (WAIS)

An individual intelligence test which is designed for subjects sixteen years of age and up. The WAIS subtests are conceptually identical to the WISC except that WAIS has only eleven subtests.

4) Stanford-Binet

The Stanford Binet Intelligence Test is one of the oldest individual intelligence tests. It was originally designed in 1905 to identify French students who were "subnormal". Since that time it has been revised several times. It has been designed to measure the general intelligence of individuals from the age of two years to eighteen years. This test, like all others, has strengths and weaknesses. It is more difficult to score than the WISC but has a higher intelligence scoring ceiling which makes it possible to test the intellectual abilities of very gifted young children (above the I.Q. of 150).

5) Slosson Intelligence Test

A short individual screening test of intelligence, for use by teachers and other professional persons for a quick estimate of mental ability.

F. DIAGNOSING POTENTIAL LEARNING DISABILITIES

1) Detroit Tests of Learning Aptitude. The Detroit tests yield a general mental age level as well as a series of subtest mental age levels. Strengths and weaknesses can, therefore, be diagnosed. This test is appropriate for individuals ages 3-0 through adult. The examiner selects from 9-13 subtests according to the diagnostic information desired. Norms are provided for converting each subtest raw score to mental age values. Instructions for the examiner are also provided for computing the I.Q. from these scores. The Detroit I.Q. is not generally regarded as a valid measure of intelligence.

2) Bender-Gestalt Test

The Bender-Gestalt Test is a paper pencil test which is composed of nine geometric designs and which involves the subject copying the designs. There is a sequencial arrangement according to difficulty. The Bender-Gestalt is a projective test. This means that subjects project aspects of their personality into the way in which they solve the test tasks. This test is useful in determining the subjects mental age up to a mental age of around 12. It is also a good test for differentiating mental retardation, cultural differences and brain damage.

3) Test of Visual-Motor Integration (VMI)

The developmental test of Visual-Motor Integration is a series of 24 geometric forms to be copied with pencil and paper. The forms are arranged in order of increasing difficulty. The test can be administered to children in the age range of two to fifteen, but it was designed primarily for the preschool and the early primary grades. The format is suitable to both group and individual administration.

Since visual-motor behavior is a composite of other behaviors, including visual perception and motor coordination, techniques for determining specific areas of difficulty are provided. They are to be used after the VMI is given. The goal of assessment is usually that of improved educational programming.

4) Illinois Test of Psycholinguistic Abilities

Ages 2 to 10; 45-60 minutes

A measure of language, perception, and short term memory skills. It is more a measure of cognitive functioning among middle class children on which it was standardized. Yields scores for auditory and visual reception, auditory and visual association, verbal expression, grammatic closure, visual closure, visual sequential memory, auditory closure, and sound blending as well as a composite psycholinguistic age.

5) Slingerland Test

Screening tests for identifying children with specific language disability. Four sets of screening tests for early grades. Group administered, informal scoring.

C. ACHIEVEMENT TESTS

1) Peabody Individual Achievement Test (PIAT).

The PIAT is a wide range screening measure of achievement in mathematics, reading recognition, reading comprehension, spelling and general information. It is an individual test that measures achievement from kindergarten through grade 12 resulting in four types of scores; grade equivalent, age equivalent, percentile ranks and standard score.

2) Wide Range Achievement Test (WRAT)

The WRAT measures achievement in written spelling, written arithmetic and oral reading from nursery school to grade 12. Each of the three achievement tests has two levels appropriate for specific ages. It usually takes less than 25 minutes to administer and score, providing achievement results in the form of grade level scores.

UNIT 4 Glossary of Terms, Bibliography

Glossary of Terms

Adaptive equipment - Relates to any equipment that has been altered for specific handicaps (the use of acetate paper with a visually impaired student).

Acuity - The sharpness of vision, poor acuity is defined as blurring.

Audiometer - An instrument used to assess the degree of hearing loss in an individual.

Autism - Form of childhood schizophrenia rendering the child non-communicative and withdrawn.

Behavior modification - The practice of applying behavior principles to educational, therapeutic and social problems.

Braille - A system of raised dots used as a written communication system for the blind.

Brailler - A machine (much like a typewriter) that prints braille.

Cerebral Palsy - Any one of a group of conditions affecting the control of the motor systems due to lesions in various parts of the brain.

Child abuse - Any physically related mistreatment directed towards a minor.

Child neglect - Mistreatment of a child in terms of dietary needs, shelter or emotional needs.

Chronological age - The child's age in calendar years and months.

Decibel - A relative measure of the intensity of sound; hearing loss is measured in decibels.

Developmental disabilities - A group of handicapping conditions which includes cerebral palsy, epilepsy, retardation and dyslexia.

Disability - A deviation in body or functioning that results in functional inadequacy in view of environmental demands.

Due process - The grievance procedure outlined by law for parents who are dissatisfied with the educational placement of their child.

Dyslexia - Impairment of one's ability to read.

ED - Abbreviation for emotionally disturbed.

EMR - Abbreviation for educably mentally retarded.

Field restriction - A loss of the field of vision in one or both of the eyes.

Fine motor - Refers to the movement of specific and usually small body parts (fingers).

Gross motor - Refers to the movement of major body parts (limbs).

Handicap - The burden imposed socially on an individual by virtue of judgement or of functional difference.

Hearing impairment - Loss of hearing severe enough to affect his/her education.

Hearing specialist - One who deals with hearing disorders including screening of potential hearing disorders and direct remedial services.

IEP - Abbreviation for the individual educational plan. This provides a concrete set of goals for the handicapped student in any educational setting.

IQ - Abbreviation for intelligence quotient determined by formal testing.

Itinerant vision teacher - One who deals with programming and delivering special services for the visually handicapped student.

LD - Abbreviation for learning disabled.

Least restrictive alternative - The most appropriate setting for a handicapped learner, as decided upon by a multi-disciplinary team of professionals including parents.

Mainstreaming - The integration of handicapped students into regular programs.

Mental age - Age determined by a standard IQ test.

Mental illness - Any emotional or physiological disorder adversely affecting an individual's mental process.

Muscular dystrophy - A disease of the muscles, characterized by weakness and atrophy of the skeletal muscles with increasing disability and deformity as the disease progresses.

Neurological - Pertaining to the normal and abnormal functions of the nervous system.

Neurosis - A mild emotional disturbance characterized by severe anxiety or exaggerated defense with personality relatively in tact.

Orthopedic handicap - Handicapping conditions relating to the lack of use in one or more limbs.

Orthopedics - Area of medicine concerned with bones, joints and muscles.

Phobia - Irrational reaction to stimuli with avoidance or escape responses.

Physical therapist - Professional technician dealing with the reconditioning of injured, deformed or semi-functional body parts.

PL 94-142 - The Education for All Handicapped Children Act of 1975. It provides the guarantee of a free and appropriate education for all handicapped children.

Pre-vocational - Pertaining to skills preparing the student for a vocationally-oriented education.

Psychiatric hospital - A facility caring for severely emotionally disturbed individuals who require constant supervision and medical care.

Residential school - A 24 hour a day live-in program.

Resource room - A physical environment where specialized instruction takes place.

Section 504 - A part of the Rehabilitation Act of 1973. This mandates non-discriminatory practices to be adhered to in the employment and education of the handicapped.

Seizure - Physical manifestation of abnormal brain activity.

Self-contained - An environment in which students receive the majority of their educational instruction.

Self-help skills - Those splinter skills used by students emphasizing caring for one's self.

Spasticity - Tightness of muscles caused from interruption of brain waves through the nervous system to muscle fibers.

Special class - A classroom in which a specific population of students are served.

Special Education - An all-encompassing term meaning any specialized instructions or service dealing with handicapped individuals.

Special school - A private school servicing students who, for whatever reason, cannot be integrated into public schools.

Speech therapist - One who is engaged in the correction of speech-related disorders.

Talking books - A collection of recorded materials used by students who cannot read the regular printed version of the text.

TMR - Abbreviation for trainably mentally retarded.

TTY - Telephone typewriter for the deaf, this communication system allows deaf individuals to communicate by phone through the use of a teletype adapter.

Visual impairment - A vision loss that affects learning.

Vocational - Of or related to instruction in a specific trade area.

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THE AUTHORS

Bob Lister is currently Chairman of the Special Education Department at Portsmouth High School in Portsmouth, New Hampshire. Mr. Lister is a graduate of Keene State College, the University of New Hampshire and is currently enrolled in a doctoral program at Peabody College, Vanderbilt University.

Vic Hnatiuk is currently the Special Education/ Vocational Education Teacher at Portsmouth High School in Portsmouth, New Hampshire. Mr. Hnatiuk graduated from Rutgers University in New Brunswick, New Jersey.